to three inches long is then made over and just beyond the great trochanter which is exposed. With a small hand drill the proper direction for the motor drill is determined by trial, as shown by observation through both wounds, the hole passing parallel to and through the centre of both fragments. The motor drill should be held ready for insertion into the tract of the hand drill as it is withdrawn by the assistant. The motor drill, which forms a hole three-eighths of an inch in diameter, is pushed through the distal fragment until the burr end of the drill appears between the fragments, as seen through the anterior wound. Just as the end of the drill is engaging the broken end of the proximal surface, a reading on the graduated drill shaft is taken at its entrance aperture in the trochanter, so that by making additional readings it can be determined how deep the capital fragment is being penetrated. By studying the roentgenogram, the length of this fragment can be very accurately determined, and hence the desired depth of the drill-hole obtained. When the fracture has occurred near the head and the proxinal fragment is consequently short, the drill-hole should extend close to the articular cartilage of the head. The drill is disengaged from the motor and left in place, to avoid any possible displacement of the fragments while the tibial graft is being procured. The crest of the lower portion of the tibia is laid bare, and an area of the desired shape and size is mapped out in the periosteum with a scalpel. The desired length of graft can be determined by the graduated scale on the motor drill. The cross section of the graft should be just large enough to be shaped into the peg when the dowel shaper is used. When the graft peg is ready, the drill is withdrawn from the femur and the peg inserted. The fit must be accurate because the dowel cutter is the counterpart of the drill used. The accuracy of fit is very important. Too tight a fit causes a pressure anemia of the surrounding cancellous bone. Too loose a fit, or an irregular, inaccurate fit, would not produce good fixation or favor an immediate bony union of graft to the host fragments. The deep fasciæ are approximated with interrupted sutures of No. 2 chromic catgut. The skin wound is closed with continuous suture of No. 1 chromic catgut. The limb is placed in abduction (Whitman) in a plaster-of-Paris spica extending from the toes to the axilla. Three weeks after the operation, windows are cut in the plaster, and the wounds dressed. The dressing should be replaced with cotton for the purpose of restoring the tension of the cast and retaining the fixation. The long spica should be continued for six weeks and followed by a short one for six weeks longer.

Cryptogenetic Peritonitis with Special Reference to the Mode of Infection of the Peritoneum.—BRUNZEL (*Deutsch. Ztschr. f. Chir.*, 1915, cxxiii, 233) says that an advance was made with the discovery of the Fränkel-Weichselbaum pneumococcus and the designation of these so-called spontaneous or idiopathic cases of peritonitis according to this, apparently, most common cause. But the new name, "pneumococcus-peritonitis," did not throw light on the mode of infection of the peritoneum. Other bacteria may be at fault as the streptococci and staphylococci. The term, cryptogenetic, is used here to designate those cases of peritonitis in which the cause is unknown or not definitely established. The most frequent cause found in the cases studied by Brunzel was the pneumococcus. He advises early operation, since the diagnosis cannot be made beforehand with certainty, although the prognosis is not good even with operation. The infection of the peritoneum occurs exclusively by the blood, in all probability. Therefore, the so-called idiopathic or cryptogenetic cases of peritonitis are more properly cases of metastatic peritonitis and the metastases should be regarded as suppurative from a general septic blood infection. The abdominal symptoms occurring in the beginning or during the course of a pneumonia may be regarded as the result of a peritoneal reaction to the flooding of the peritoneum with pneumococci. When the infection gains the upper hand of the peritoneal resistance, the peritonismus becomes a peritonitis. The cases reported as localized pneumococcus peritonitis are to be strictly differentiated from those of general peritonitis. The prognosis is more favorable and for the greatest part, at least, these cases are confused with abscesses of the space of Retzius, which may be metastatic by the blood path or the result of the breaking down and extension of the suppuration from an infected lymph node.

Neurolysis of the Brachial Plexus.—Mehler (*Deutsch. Ztschr. f. Chir.*, 1915, cxxxiii, 299) reports from his experience in the present European war, the following case in which a gun-shot wound is supposed to have passed through Erb's point in the brachial plexus (junction of fifth and sixth roots of the plexus), and was followed by a complete flaccid paralysis of the arm which is supposed to have been due to the rupture of the plexus at Erb's point. The soldier was wounded October 2, 1914, and admitted to the hospital October 9, 1914. The wound of entrance was at the upper inner angle of the right scapula, the wound of exit just above the clavicle at Erb's point. The right arm was completely motionless (flaccid paralysis). Sensation was preserved. On examination the right arm hung flaccid, active movements were impossible, slight finger movements were present and all reflexes were lost. There was no response to the galvanic or faradic current, from the brachial plexus or the individual nerves and muscles. The condition remained unchanged to the end of December. The region of the brachial plexus was exposed by operation, January 5, 1915. Above and below the clavicle, the plexus was widely and firmly adherent to the surrounding tissues and extended as a broad plate, indistinguishable from the surrounding tissue, and showed tense cords especially posteriorly and lateralward. The plexus was separated, in part bluntly, in part by dissection, and the wound closed. Primary healing followed. Examination on January 22, 1915, showed a weak response of the plexus to the faradic and galvanic currents. There was slight movement of the arm, beginning supination and improved finger movements. On February 13, 1915, the hand and finger movements were almost normal and in the elbow-joint there were slight flexion and extension. The deltoid showed mild contraction. Still further improvement was noted on March 24, 1915.